Maryland
DEPARTMENT OF HEALTH

# Maryland Medicaid's Maternal Opioid Misuse Model—Best Practices and Expectations for Case Management, Staffing and Workflow

*Version 4.0 (18 November 2021)*

| Version | Date | Change Log |
|---|---|---|
| 1.0 | 1/25/21 | N/A |
| 2.0 | 4/14/21 | Case management workflow timeline, self-report question list, and further Release of Information requirement information added; included guidance on data and document storage and case management appointment locations |
| 3.0 | 6/9/21 | Further guidance on CCM access, ROI completion, OUD diagnosis requirement and self-report template provided; eligibility checklist for MOM enrollment added |
| 4.0 | 11/17/21 | Updated OUD diagnosis requirement and related checklist; clarified expectations around substance use treatment engagement; added guidance on inpatient stays |

## Executive Summary

The purpose of this document is to outline the accepted case manager provider types, staffing related needs and expectations, as well as workflow to fulfill the case management aspect of the Maternal Opioid Misuse (MOM) model. This document is meant to be used as a resource for MCOs to refer to while finalizing their staffing plans and preparing for implementation. Additionally, the case management workflow section of this document provides a detailed overview of the associated tasks required at various points during a participant's engagement in the model to fulfill the requirements needed to receive per member per month (PMPM) payments.

## Background

The Maryland Department of Health (the Department) launched its MOM model in January 2020, with funding from the Center for Medicare and Medicaid Innovation (CMMI) and in collaboration with the Centers for Medicare and Medicaid Services (CMS). The MOM model focuses on improving care for pregnant and postpartum Medicaid participants diagnosed with opioid use disorder (OUD). Substance use is a leading cause of maternal death and has a significant impact on the approximately 1,500 infants born to Medicaid participants with OUD in Maryland per year. Maryland's MOM model addresses fragmentation in the care of pregnant and postpartum Medicaid participants with OUD through collaborative efforts with its managed care organizations (MCOs), improved data infrastructure and strengthened provider capacity in underserved areas of the state. The MOM model aims to increase utilization of physical and behavioral health care services, such as medication for opioid misuse disorder (MOUD), as well as to address health-related social needs, for this population through enhanced MCO case management.

## Best Practices

### Case Management

The Substance Abuse and Mental Health Services Administration (SAMHSA) has described *case management* as a coordinated approach to the delivery of health and social services, linking clients with appropriate resources to address specific needs. SAMHSA notes that effective case management consists of the following set of functions: (1) assessment; (2) planning; (3) linkage; (4) monitoring; and (5) advocacy.[1] Similarly, *case manager* has been defined as an individual responsible for executing case management activities, including assessment of needs, service planning, service plan implementation, service coordination, monitoring and follow-up, reassessment, case conferencing, crisis intervention, and case closure.[2]

Case Managers can serve as a single point of contact for participants who receive services from various entities. For the purposes of the Maryland MOM model, MOM case managers will serve as the "quarterback of care," ensuring participants enrolled in the MOM model not only receive needed health care services but also gain access to and remain connected to appropriate social services in the community. The overarching goal of comprehensive and coordinated case

[1] Center for Substance Abuse Treatment. Comprehensive Case Management for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 15-4215. Rockville, MD: Center for Substance Abuse Treatment, 2000. Retrieved from: https://store.samhsa.gov/system/files/sma15-4215.pdf

[2] New York State Department of Health AIDS Institute. Standards for HIV/AIDS Case Management. 2006. Retrieved from: https://www.health.ny.gov/diseases/aids/providers/standards/casemanagement/docs/casemanagementstandards.pdf

management is to reduce barriers that impede access to and/or compliance with treatment. Research has shown that retention in Substance Use Disorder (SUD) treatment is more likely when other social needs are addressed concurrently.[3] Such needs include, but are not limited to: housing supports, food assistance, vocational services, educational resources, transportation, child care, legal assistance and peer support.[4]

Other best practices for case management through the MOM model involve:

- Developing and revisiting MOM care plans during face-to-face meetings[5] and negotiating between MOM model participants and MOM case managers to encourage active participation and empowerment;
- Jointly developing measurable goals and activities—taking into consideration the participants' cognitive and physical abilities, available resources, support networks and motivations—that result in a more realistic, MOM model participant-specific care plan;
- Offering a copy of the MOM care plan to the participant, reinforcing participant ownership and involvement in the case management process;
- Documenting changes or updates to the MOM care plan as well as actual outcomes to track MOM model participant progress;
- Engaging family members and the participant's support network to assist in ensuring a MOM model participant receives needed service, including inclusion in the MOM care plan to carry out activities;
- Strengthening data-sharing and communication between MCOs and the Behavioral Health Administrative Services Organization (BH ASO); and
- Building relationships between MCOs, Local Health Departments (LHDs), and Local Behavioral Health Authorities (LBHAs) to leverage unique local opportunities and programs for MOM model participants.

## Staffing

While MCOs must include one or more Medicaid-approved qualified provider type as the designated MOM case manager(s) in their staffing model (see below for eligible provider types); MCOs may enlist lay health workers, such as community health workers (CHWs) and Certified

[3] Substance Abuse and Mental Health Services Administration. Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series, No. 51. HHS Publication No. (SMA) 13-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009. Retrieved from: https://store.samhsa.gov/system/files/sma15-4426.pdf

[4] Center for Substance Abuse Treatment. Medication for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series No. 63. HHS Publication No. (SMA) 18-5063. Rockville, MD: Center for Substance Abuse Treatment, 2018. Retrieved from: https://medicine.yale.edu/edbup/quickstart/TIP_63_338482_42801_v1.pdf

[5] If possible by the start of MOM enrollment in July 2021.

Peer Recovery Specialists (CPRSs), to support engagement and outreach activities. CHWs typically belong to the same communities as the individuals they serve and are a provider type that may be beneficial in improving the quality and cultural responsiveness of care.[6] Similarly, CPRSs offer non-judgmental, practical information for individuals with OUD and provide unique insights through their lived experiences.[7,8] Evidence demonstrates that utilization of peer recovery specialists and other paraprofessionals is a promising practice for continued engagement among individuals with OUD.[9] As an illustrative example, a CPRS could perform the following functions:

- Naloxone education and distribution;
- Referrals to community resources-ongoing, warm handoffs at discharge;
- Appointment reminders, follow up calls, and assisting with eliminating barriers to accessing care (*i.e.*, transportation, child care);
- Outreach to disengaged MOM model participants; and
- Accompany to clinician visits with MOM model participants.

With regard to staffing ratios, the Improving Mood: Providing Access to Collaborative Treatment (IMPACT) model utilized one full-time case manager for a caseload of 100-120 participants. IMPACT case managers include clinical social workers, master's level counselors/therapists, nurses, and psychologists.[10] Another, the Mental Health Integration Program (MHIP) had a typical caseload of 50-75 participants per one full-time case manager; however, larger caseloads were managed with support from community health workers. MHIP targets mental health and substance use conditions, and case managers include social workers and nurses.[11] The Collaborative Care Model (CoCM) varies the caseload per full-time case manager based on the target population characteristics. The CoCM has substantiated that a full-time case manager could have a lower caseload of 60-80 participants if they were Medicaid enrollees diagnosed with behavioral health conditions and had limited social supports. CoCM

[6] American Public Health Association. Community Health Workers. (n.d.). Retrieved from: https://www.apha.org/apha-communities/member-sections/community-health-workers

[7] Certified Peer Recovery Specialists: https://bha.health.maryland.gov/Documents/CPRS%20Overview%20Guide_comms_030518.pdf

[8] Dardess, P., Dokken, D. L., Abraham, M. R., Johnson, B. H., Hoy, L., & Hoy, S. (2018). Partnering with patients and families to strengthen approaches to the opioid epidemic. Bethesda, MD: Institute for Patient- and Family-Centered Care.

[9] Ibid.

[10] Unützer, J., Katon, W., Callahan, C., Williams, J., Hunkeler, E., Harpole, L., Langston, C. (2002). Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. JAMA, 288(22), 2836-2845.

[11] Vannoy, S., Mauer, B., Kern, J., Girn, K., Ingoglia, C., Campbell, J., Unützer, J. (2011). A Learning Collaborative of CMHCs and CHCs to Support Integration of Behavioral Health and General Medical Care. Psychiatric Services, 62(7), 753-758.

behavioral heath care managers include nurses, social workers, psychologists, and licensed counselors.[12,13]

## MOM Model Provider Types and Staffing

### Provider Types

The provider types that may provide case management and care coordination services in Maryland Medicaid for the MOM model are as follows: physician, physician assistant, nurse practitioner, nurse midwife, registered nurse, licensed clinical social worker, psychologist, certified professional counselor, and psychiatric nurse. It is important to note that Maryland Medicaid does not currently reimburse for services rendered by certified peer recovery specialists (CPRS). An MCO could consider using CPRS and/or CHWs in their case management staffing model, which could be supported by the PMPM rate for enhanced case management activities, although secondary supports are not a requirement for the model.

### Staffing Ratios

As described above, the Department identified several integrated health models to gain an understanding of an effective participant-to-case manager ratio. Findings from the review conducted determined that while ratios summarized for these cited models were higher than the Department's expectations for the MOM model, none of the models had the service delivery and care coordination activities that will be required for case managers to conduct on a monthly basis. Due to this, MCOs should consider substantially lower staffing ratios to accommodate the case management level forecasted to ensure success of the model. It should also be noted that case management activities that will be required and outlined in this document represent a bundle of enhanced services different from those already offered to pregnant and postpartum MCO participants.[14,15]

Bridging the gap between primary care, behavioral health treatment, obstetric care, and other social service needs requires a dedicated full-time case manager. Each MCO should employ or contract with qualified case managers to render the services described in this document. The

[12] AIMS Center. Guidelines on Caseload Size for Behavioral Health Care Managers and Psychiatric Consults. University of Washington: 2017. Retrieved from: http://aims.uw.edu/sites/default/files/Behavioral%20Health%20Care%20Manager%20Caseload%20Guidelines_072120%20Final.pdf

[13] AIMS Center. Behavioral Health Care Manager. Retrieved from: http://aims.uw.edu/collaborative-care/team-structure/care-manager

[14] COMAR 10.67.06.21: http://www.dsd.state.md.us/comar/comarhtml/10/10.67.06.21.htm

[15] COMAR 10.67.04.08: http://www.dsd.state.md.us/comar/comarhtml/10/10.67.04.08.htm

number of case managers per MCO needed to implement the MOM model depends largely on the number of eligible participants within each MCO. The Maryland MOM model proposes having a ratio of one MOM case manager per 30 MOM model participants (1:30) due to the substantial amount of care coordination and associated tasks required by MOM case managers to fulfill the requirements of the MOM model (outlined below) and to adequately address the myriad social and health needs for this vulnerable population.

Additionally, while MCOs are charged with providing the MOM model enhanced case management and care coordination services described in this document, MCOs may choose to partner with other entities, such as LHDs, to provide the MOM services on the MCOs' behalf.

## Case Management Workflow - Associated Tasks and Timeline

MOM case managers will need to conduct certain tasks throughout a participant's engagement in the model and ensure the fulfillment of model requirements within a timely manner to receive PMPM payments.

It is imperative that MOM case managers document all MOM related tasks within the MOM Care Coordination Module (CCM), hosted by CRISP, in addition to documentation that would normally occur separately within their native electronic health record (EHR). MOM case managers will need Wi-Fi or cellular access to use the CCM, a web-based portal. Continually updating this information for all assigned MOM model participants within the MOM CCM, on at least a monthly basis, will be vital for MCOs to receive PMPM payments. Documentation within the MOM CCM will also play an essential role in the monitoring and evaluation components of the grant to measure the impact of model services, which is tied to the possibility of additional MOM milestone funding. Successful completion of MOM interventions could result in incentives through this type of funding.

Please use this guide as a reference for associated tasks to be completed during the phases of participant engagement and the timeline to ensure compliance with the model. This document may be updated periodically with supplementary tasks (*e.g.,* screening requirements) as needed, should CMMI request additional measures to be reported for grant monitoring and evaluation activities.

### Pre-Enrollment: Referral Pathways and Eligibility Screening

- MCOs identify potentially eligible participants through the following avenues and forward referrals to MOM case managers:

    - *No wrong door referral from other agencies: LHDs, LBHAs, law enforcement, EDs, somatic and BH providers, DHS*
    - Screening, Brief Intervention and Referral to Treatment (SBIRT)
    - Maryland Prenatal Risk Assessment (MPRA)
    - MCO data-mining and enrollment screening
    - Referral from the BH ASO
    - Referral from a community-services organization (CSO)
    - See also: Participant Engagement Strategies Brief
- MOM case managers receive referrals and contact identified potential participants to verify interest and confirm clinical eligibility (See Appendix A for an Eligibility Checklist)
    - Current MD state resident residing in the MOM target area[16]
    - Current HealthChoice member
    - Currently pregnant (cannot enroll postpartum)
    - OUD Diagnosis - Must have a formal OUD diagnosis, at any point in participant's medical history, or be willing to attest to a current or previous history of OUD[17] before the participant enrolls into the model. (See Appendix B for additional guidance.)
- Schedule an intake appointment (conducted in-person)[18]
    - Review approximate length of appointment and what to expect during session
    - In-person intake appointments could occur in the following locations, according to participant preference: MOM model participants' residence; private rooms in the local library; local health department; housing shelter or temporary housing (*e.g.*, motels); pregnancy centers; clinician offices; parks; unhoused encampments, or other locations as agreed upon by MOM participant and MOM case manager.
- Coordinate with the BH ASO to confirm Part 2 Release of Information completion

Participants must be enrolled during pregnancy prior to delivery as one aspect of eligibility. As part of a strategy for identifying participants, a goal of the MOM model will be to increase both the amount of MPRAs completed by providers in a timely manner as well as streamline the routing of MPRAs via ACCUs to MCOs to assist with identifying pregnant beneficiaries with OUD earlier in their pregnancy. Due to claims lag, the Department encourages MCOs to identify innovative ways other than data-mining to identify and recruit potentially-eligible participants on the front-end as part of their staffing plans for the MOM model. If data-mining is warranted,

[16] As of April 2021, St. Mary's County

[17] Self-attestation along with documented OUD screening will satisfy formal OUD diagnosis. This documentation must be captured in MOM CCM

[18] Subject to change

the following HCPCS codes are specifically related to prenatal care: H1000 and H1003. Please note the identification and use of these codes may not be a reliable method for identifying potentially-eligible participants in a timely manner. Other approaches should be exhausted first.

It is important to note that, although the MOM model encourages participants to seek or maintain treatment for OUD, engagement in treatment is not a prerequisite for model eligibility and enrollment. Additionally, participants are welcome to continue in the model even if, over the course of their participation, they no longer have their infant for reasons such as adoption, CPS involvement and fetal demise.

To be considered eligible to participate in the MOM model, participants must have an OUD diagnosis before enrolling into the MOM model. To ascertain an OUD diagnosis, MCOs must look in their data for history of OUD-related codes for the potential participant; if no history is found, MCOs must consult with the BH ASO to look in its data. Appendix C outlines a list of ICD-9 and ICD-10-CM codes that constitute an OUD diagnosis for the purposes of the MOM model. MCOs must also engage with the BH ASO and check for Part 2 release of information (ROI) to assist in verifying a participant's clinical eligibility during the pre-enrollment screening process. The BH ASO will collaborate with MOM case managers to ensure Part 2 ROIs are obtained for consenting MOM participants.

If Part 2 ROI cannot be obtained in a timely manner and/or a potential participant does not have a claims history that indicates an OUD diagnosis, MOM case managers will be advised to coordinate with the potential participant for a verbal self-attestation of current or previous history of OUD before enrolling into MOM model services. The self-attestation process is meant to address barriers to enrolling participants in a timely manner. MCOs may proceed to setting up an intake appointment while simultaneously following the search procedures to verify or confirm a claims history of OUD on these participants. MCOs will need to document attempts to identify OUD diagnosis - in managed care encounters and behavioral health claims - in the MOM CCM by the time of enrollment following the guidance outlined below for these participants.[19]

In the case that self-attestation is required,MOM case managers should administer the OUD screening tool (see Appendix B) with participants who self-report their OUD and document date screening was administered and level of severity to satisfy the formal OUD diagnosis requirement. In addition, if a MOM case manager is clinically-licensed to provide a diagnosis,

[19] Dates MCO checked their system and coordinated with Optum to verify OUD would be documented in the Medications and clinical conditions field of the MOM CCM intake form until an Other section can be built out in future enhancements

they should record that information into the MOM CCM, according to the clinical OUD diagnosis indicators in Appendix C.

Figure 1 below displays the pre-enrollment workflow. Table 1 below depicts a high-level summary of associated tasks and expectations throughout a participant's participation in the model. Additional detail follows the table.

**Figure 1. Pre-Enrollment Workflow**

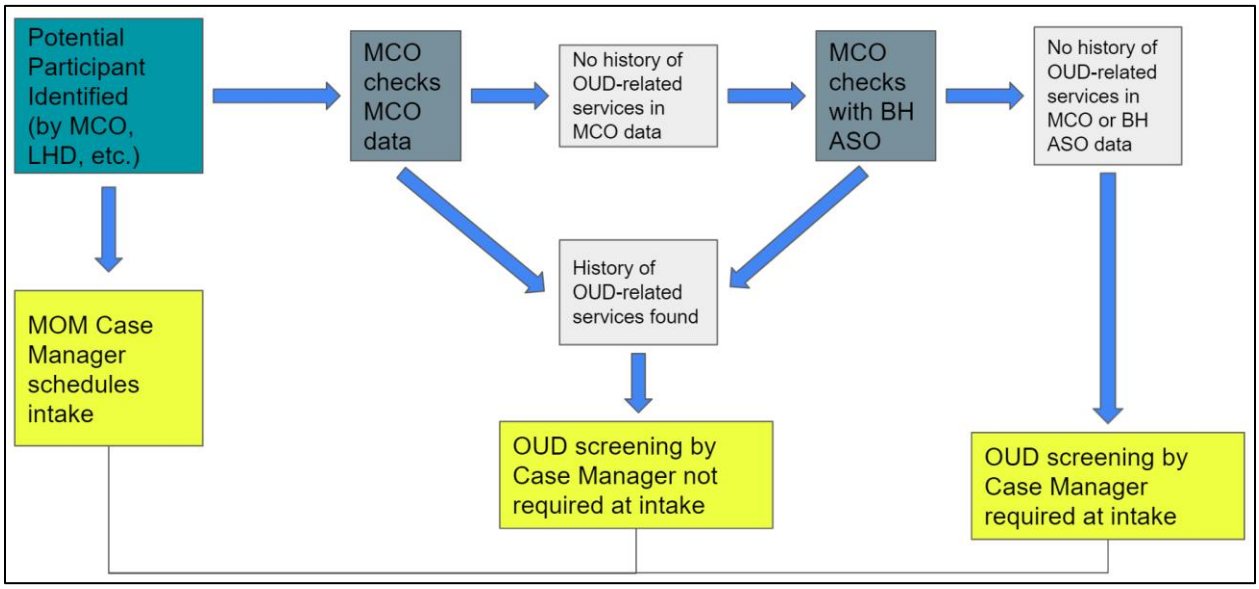


**Table 1. Case Management Workflow Timeline**

| | **Pre-enrollment** | **Intake** | **Ongoing Enrollment** | | | | **Substantial outreach** | **Discharge** |
|---|---|---|---|---|---|---|---|---|
| Associated Activities | Month 0/Referral | Initial Visit/Month 1 | Month 2 | Months 3-8 (Third Trimester) | Postpartum (up to 60 days) | 60 Days Postpartum- Infant's 1st birthday | Anytime/Multiple Periods of up to 2 Months | Final Enrolled Month |
| Screenings | Confirm interest and clinical eligibility: current St. Mary's county resident, HealthChoice member, pregnant, formal OUD diagnosis (or self-attestation) | All required intakes, **HRSN** (with depression, tobacco, alcohol embedded), **PHQ-9** (if positive result from HRSN), **GAD-**7. **PAM, Self-Report Template** | | *During third trimester:* **HRSN** (with depression, tobacco, alcohol embedded), **PHQ-9** (if positive result from HRSN)<br><br>**PAM** at 90 days | **HRSN** (with depression, tobacco, alcohol embedded), **PHQ-9** (if positive result), **GAD-7, Self-Report Template, NIDA ASSIST SUD** | Every 3 months- **HRSN** (with depression, tobacco, alcohol embedded), **PHQ-9** (if positive result) | N/A | **HRSN** (with depression, tobacco, alcohol embedded), **PHQ-9** (if positive result), **GAD**-7 |
| Monthly in-person visits/contact | Schedule intake appointment<br><br>Contact BH ASO to confirm Part 2 ROI completion | | At least one Core Component | At least one Core Component | At least one Core Component (provide at least health promotion component including providing naloxone post-delivery check-in) | At least one Core Component | At least 3 outreach attempts with two different methods, up to 2 months | At least one Core Component |
| Care plan and documentation | Document intake appointment date/time | New case development MOM CCM, Goal Creation (2-3 goals) | Goal Check In, MOM CCM documentation | Goal Check In, MOM CCM documentation | Goal Check In, MOM CCM documentation | Goal Check In, MOM CCM documentation | Document dates and outreach methods in MOM CCM | Review Goals, provide linkages, document activities and update discharged status in MOM CCM and send care alert |

| | Pre-enrollment | Intake | Ongoing Enrollment | | | | Substantial outreach | Discharge |
|---|---|---|---|---|---|---|---|---|
| Associated Activities | Month 0/Referral | Initial Visit/Month 1 | Month 2 | Months 3-8 (Third Trimester) | Postpartum (up to 60 days) | 60 Days Postpartum- Infant's 1st birthday | Anytime/Multiple Periods of up to 2 Months | Final Enrolled Month |
| MOM Participant responsibilities | Answer OUD Dx screening (if applicable) and eligibility questions, confirm Medicaid ID, and sign Part 2 ROI (if outstanding) | Sign informed consent; Have at least 1 BH or somatic visit | Have at least 1 BH or somatic visit | Have at least 1 BH or somatic visit | Have at least 1 BH or somatic visit | Have at least 1 BH or somatic visit | N/A | Have at least 1 BH or somatic visit |

## During Intake: First Month of MOM Participation

- Informed Consent
    - Explain program requirements and participant rights to voluntarily participate and withdraw, and answers any questions participants raise
    - Collect participant signature for informed consent and any other intake forms in addition to those required by the MOM model
- Initial Care Plan
    - Develop jointly during intake session
    - Confirm/collect participant contact information, denote preferred contact method, and emergency/secondary contacts
    - Confirm/collect information on all providers participant is currently under the care of and their contact information
    - Identify 2-3 goals based on participant identified areas of need, to be reviewed during every monthly meeting and updated as needed
- Screenings that must be completed within 7 days of model enrollment (The Department recommends these be conducted during the initial intake visit, as all components are required to enroll participants into the model and results of these screenings may influence the care plan.) (See Appendices C and D for additional detail.)
    - *HRSN screening* – Administer MOM model adapted AHC screening tool located within CRISP.
    - *Depression screening* – captured through HRSN screening tool using the same screening and scoring methodologies as the PHQ-2; administer the PHQ-9. separately and create a follow-up plan for those who screen positive (score of 3 or above on PHQ-2 questions).
    - *Anxiety screening* – captured through separate GAD-7 screening, with indication of participant's level of anxiety documented.
    - *Tobacco screening* – captured through the HRSN screening tool; refer to tobacco cessation for those who screen positive.
    - *Alcohol screening* – captured through the HRSN screening tool.
    - *Patient Activation Measure (PAM) screening* – entered into the Flourish tool administered by Insignia Health, document completion into care plan.
    - *Self-Report Template* – administered by the MOM case manager to fulfill data collection requirements; questions 1 through 11 asked at intake (or in third trimester once rapport is established).
    - *OUD screening* – required only for participants who self-attest their OUD, using the screening provided in Appendix B of this case management manual. Based on DSM-V criteria, specify if level of severity is mild, moderate, or severe and if in remission.

- Care coordination activities
    - Provide referrals based on identified areas of need
    - Ensure needed medical appointments are made for the upcoming month, such as prenatal care visits and specialty behavioral health care visits
    - Coordinate care and establish and/or increase communication between/among participant's providers across systems of care, including with the BH ASO's care coordinators, as needed
- Documentation
    - Create new case in MOM CCM for the participant and populate.
    - Log into CRISP ULP and access the patient snapshot where participants' providers and clinical conditions are captured and add relevant information.
    - Indicate that informed consent has been signed in Care Coordination Module
    - Save a hard copy of the signed consent, outside data template and self-report questions, PHQ-9 (if administered) GAD-7 and OUD (if participant self-attests) screenings in a secure place
        - Note: In the future, the CCM may build the self-report template into the CCM, but at this time it needs to be administered and stored outside of the CCM. The PHQ-9 and GAD-7 screenings will be linked via PDF within the CCM but will also need to be administered and stored outside of the CCM.
    - Document completed tasks into the module (consent, initial MOM care plan, screenings provided, contact information, care team, patient visit and contact type)
    - If participant must self-attest to OUD: Document dates of MCO and ASO verification checks, date OUD screening tool administered and level of severity of OUD
        - Note: OUD screening will be stored outside of the CCM. All documentation related to this screening will be documented in the Medications & Clinical Conditions section of the MOM Initial Care Plan until otherwise specified.

### During Enrollment: Second month of MOM participation through 60 days postpartum

Participants will be engaged in MOM model services from the time of enrollment up to the infant's first birthday so long as the MOM model participant remains enrolled in Medicaid[20] and continues to meet the following requirements to be considered active.

[20] Participants who do not remain income-eligible for Medicaid such as after 60 days postpartum or lose Medicaid coverage will no longer be eligible to participate in the MOM model.

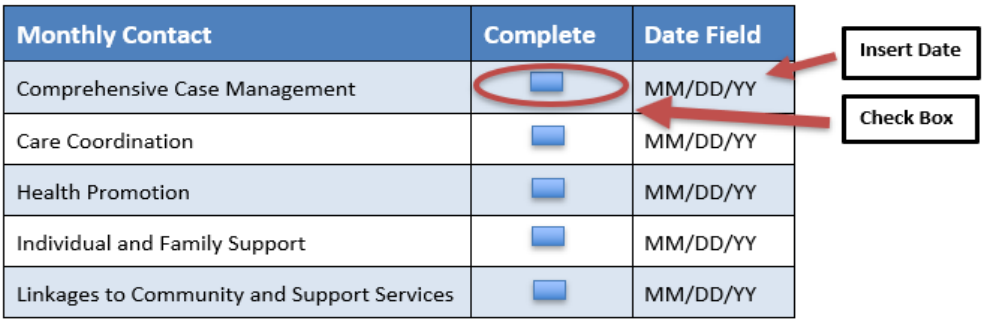
### Requirement 1: Monthly Case Management Visits and Model Requirements

On a monthly basis, MOM case managers will be expected to fulfill at least one of the five core components of the Maryland MOM model in, at a minimum, the following ways:

1. Comprehensive Case Management
    - Initial needs assessment and SDOH screening
    - Development and periodic reassessment of MOM care plan
    - Supportive shared decision-making process to understand and select from the landscape of health-related social needs resources
2. Care Coordination
    - Appropriate linkages to somatic and behavioral health providers as identified within care plan for the MOM model participant
    - Following up on needed services and supports
    - Serving as the established MOM case manager for different providers and CSOs serving the MOM model participant
3. Health Promotion
    - Discussing recurrence of symptoms and creating a safety plan
        - Providing naloxone to the participant and educating friends/family on use of naloxone
    - Providing literature on Maryland Crisis Connect
        - Available 24/7 to people in need of crisis intervention, risk assessment for suicide, overdose prevention, support, guidance and information or linkage to community behavioral health providers
    - Discussing options for family planning
    - Nutritional counseling
    - Wellness programs
    - Education about STIs and other infectious diseases; e.g., viral hepatitis and HIV/AIDS Preventive healthcare education
    - Assisting with medication adherence
    - Educating family regarding appropriate infant developmental milestones and healthy attachment behaviors
4. Individual and Family Supports
    - With participant permission, involving partner and/or family in care activities
    - Training family about the role of recurrence of use and use of naloxone
    - Connecting families and children with needed supports such as parenting classes or family counseling
5. Linkages to Community and Support Services
    - Connecting participants to resources related to the SDOH screening by completing warm handoffs with programs embedded in LHDs as well as LBHAs and CSOs, such as disability benefits, social services, SUD treatment, housing, legal services, life skills training and educational/vocational training and using CRISP's envisioned referral and community resources platform

The MOM case manager will be responsible for fulfilling at least one of the five core components listed above at least once monthly. The MOM case manager will then document which core component was completed in the Care Coordination Module under the 'Monthly Contact' tab by checking a box and inserting a date into the date field. This should be considered a minimum; MOM case managers are encouraged to provide as many of the five components on a monthly basis as are needed by the MOM model participant.

**Figure 2. Monthly Contact in Care Coordination Module (Illustrative)**




### Requirement 2: Monthly Health Service Utilization

MOM case managers will need to ensure MOM model participants receive at least one behavioral health and/or somatic health visit each month in addition to conducting monthly case management contacts. Examples of behavioral health and somatic health visits are included in Table 1 below.

**Table 2. Qualifying Monthly Visits, by Behavioral and Somatic Health Categories**

| Behavioral Health Visits | Somatic Health Visits |
|---|---|
| Alcohol and/or drug assessment | Primary Care |
| SBIRT | Specialty Care |
| Individual Therapy and/or Group Therapy | Federally qualified health center (FQHC) or other clinic services |
| Family psychotherapy and psychoeducation | Family Planning |
| Medication Management | Dental services for pregnant individuals through date of delivery |
| Opioid maintenance therapy for individuals 18 years or over | Habilitation Services for Expansion Populations:<br>(1) Physical therapy;<br>(2) Occupation therapy; and<br>(3) Speech therapy |
| Intensive Outpatient (ASAM Level 2.1) | OB/GYN Care- Prenatal, perinatal, and postpartum care visits |
| Partial Hospitalization (ASAM Level 2.5) | Labor and Delivery services |
| Ambulatory Detox | Newborn Care and Well Child visits |

*Please note that provision of MOUD does not qualify as a behavioral health visit under the MOM model.

### Periodic Re-assessments of Screenings and Care Plan

To identify early recurrence of use and prevent fatal overdose, MOM case managers will screen participants for both postpartum depression as well as SUD. Please refer to Appendix D for the frequency of re-assessments for each screening.

*Documentation*

- Document completed tasks into the module (re-assessment of participant goals and indicated barriers, screenings provided (including an indication substance use screening was administered postpartum), contact information, care team, patient visit and contact type)
- Store outside data template and self-report questions, PHQ-9 (if administered), SUD, and GAD-7 screenings in a secure location
- Document model core elements provided during visits including health promotion activities surrounding screening for SUD and naloxone distribution provided after delivery
- Document any contact attempts and type of outreach made when participant misses appointments and case management visits
- For MOM model participants losing Medicaid coverage at 60 days postpartum: Assess for outstanding needs, provide referrals to on-going services, as needed, change MOM model enrollment status into the module and submit a care alert indicating the participant is no longer active

## During Enrollment: 60 days postpartum through infant's first birthday

To meet requirements stipulated by CMMI, MOM model participants who lose Medicaid eligibility will no longer be eligible for services, even if their infant remains enrolled in Medicaid.[21] MOM case managers are encouraged to work with those at risk of losing Medicaid coverage at 60 days postpartum to seek alternative health coverage, such as subsidized health plans available through the Maryland Health Benefit Exchange. For MOM model participants that do not lose Medicaid eligibility after two months postpartum, enhanced MOM model case management services will continue until the infant's first birthday.

### Monthly CM Visits and Model Requirements

- MOM case Managers will still need to ensure they are providing monthly Case Management visits and fulfilling at least one of the five core elements for the remainder of the participant's time in the MOM model. MOM case managers will need to ensure MOM model participants receive a minimum of one behavioral health or somatic health visit each month in addition to conducting monthly case management contacts.

[21] As a result of enabling legislation in 2021 from the Maryland legislative session, Maryland intends to expand coverage to 12 months postpartum, expected in 2022.

### Re-assessments of Screenings and Care Plan

- *Care Plan* – Re-assess participants needs and goals and revisit care plan on a monthly basis and update goals as needed
- *HRSN Tool* – Re-administer screening after 60 days postpartum every three months or as needed. Administered a final time during the last month of a participant's enrollment
- *Self-Report Template* – administered by the MOM case manager for data collection purposes; questions 12 through 25 asked within 60 days of the postpartum period

*Documentation*

- Document tasks into the MOM CCM (consent, re-assessment of participant goals and indicated barriers, screenings provided, contact information, care team, patient visit and contact type)
- Store outside data template and self-report questions, and PHQ-9 (if administered) screening in a secure location
- Document model core elements provided during visits
- Document any contact attempts and type of outreach made when participant misses appointments and CM visits

## Disengaged Participants and Outreach Process

***Maximum of two months if MOM model participants are lost to follow-up***

Substantial outreach is a specific protocol for re-engaging MOM model participants that MOM case managers will follow in the event that MOM model participants become disengaged from care (e.g. miss a doctor's appointment or miss a monthly MOM case manager contact). With documentation logging the date and type of each contact attempt described in additional detail below, MCOs will receive a PMPM payment for providing substantial outreach for disengaged beneficiaries for up to two months. There are a variety of loss-to-follow-up activities that the Department will accept to continue the PMPM payment.

**Highlight: Enrolled MOM participants who enter inpatient treatment**
If an already-enrolled MOM participant enters inpatient treatment for a month or longer—and case management activities are not possible—MCOs are not eligible for PMPM payments for that month. Upon discharge, MOM participants may continue in the model without needing to re-perform intake activities but may conduct re-assessments to inform an updated care plan.

MOM case managers will need to follow outreach guidelines for enrolled participants when they first become disengaged from services. Before transitioning a participant to the substantial outreach phase of participation, MOM case managers will need to make three contact attempts, to be logged in CRISP-based care coordination module:

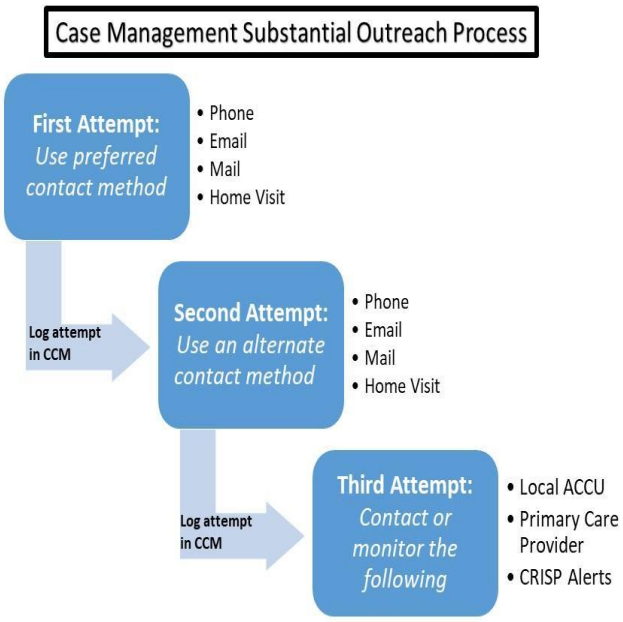
- First attempt using preferred method of contact as identified in the Maryland Health Connection
- Others may include phone, email, mail, and home drop by visits

If participants can still not be re-engaged after following the above procedures, they will be considered lost to follow-up and provided two months' worth of substantial outreach. Potential outreach strategies may include the following:

- Use Healthy Families America and Nurse-Family Partnership home visiting model protocols;
- Contacting participants' family members, friends, partners, and emergency contacts via phone multiple times at different times of day;
- Sending mail correspondence to the participant's home or listed addresses;
- Deploying assigned MOM case manager or other assigned care plan team members (*i.e.,* CPRS and/or CHWs) to the participant's home and/or community, including on evenings or weekends;
- Contacting participant's primary care provider and other providers to assist with reengagement;
- Connecting with local ACCUs or other connected departments and community programs participant is involved with (i.e. DPSCS; DHS);
- Monitoring CRISP hospital utilization alerts to check inpatient admissions and emergency encounters; and
- Log three attempts at minimum per month into the care coordination module. The three attempts should be at least two different types of follow-up, such as two phone calls and one letter in the mail. The third attempt could also involve other systems as demonstrated in the following visual.
- See also: Participant Engagement Strategies Brief

To qualify for a PMPM payment, substantial outreach activities must be conducted and documented during each month, for multiple periods of up to two consecutive months.

**Figure 3. Case Management Substantial Outreach Process by Month**




## Discharge Planning

*Last month before infant's first birthday or at case closure*[22]

- Conduct final case management visit, providing at least one core model component
  - Linkages (wrapping up connecting MOM model participant to social needs)
  - Health promotion (*e.g.,* providing naloxone; family planning materials)
  - Care coordination and warm handoffs
- Assess outstanding needs
  - *Care Plan* – Review developed goals, determine areas that may need continued support, and provide a discharge plan to participant upon the end of services
  - *HRSN Tool* – Final screening and referrals
  - *Anxiety screening* – If needed
  - *Depression screening* – Provide linkages to on-going supports if positive screening
- Documentation
  - Document all tasks and relevant screenings into the MOM CCM
  - Store any outside forms collected, PHQ-9 (if administered) and GAD-7 screenings in a secure location

[22] Discharge planning activities do not need to be completed if a MOM model participant is being discharged due to reasons other than completing services such as loss to follow-up. Ensure all outreach attempts are logged into the module and follow only the documentation section in these instances.

- Indicate status of MOM enrollment and notate if participant was discharged due to loss to follow-up or if they completed services
- Submit care alert indicating participant is no longer active

## Appendix A: Eligibility Checklist for MOM Model Enrollment

*For use by MOM case managers as needed to confirm clinical eligibility for potential participants before enrolling them in the MOM model. If using self-attestation for potential participants who have no diagnosis codes and/or claims history of OUD, the OUD screening tool must be administered and documented appropriately during the initial intake visit.*

☐ Confirm participant is a Maryland state resident residing in St. Mary's County

☐ Confirm participant is a current HealthChoice member

☐ Confirm participant pregnancy status is current

☐ Confirm participant has an Opioid Use Disorder diagnosis

- ✓ Check historical records of MCO claims (see Appendix B in the Case Management Manual for ICD-9 and ICD-10 codes) ***or***
- ✓ If not confirmed through MCO claims, engage the BH ASO to confirm OUD diagnosis through BH ASO data ***or***
- ✓ If not confirmed through either MCO or ASO data, administer OUD screening during intake (see Appendix B in the Case Management Manual for DSM-V criteria) and document in MOM CCM the following information:
  - Dates of data checks by MCO and BH ASO;
  - Date OUD screening tool administered; and
  - Level of severity of OUD.

☐ Confirm with the BH ASO completion of the Part 2 Release of Information

- If not completed, collaborate with the BH ASO to have the ROI signed
- If refusal to sign, please contact the MOM team at MDH

## Appendix B: OUD Diagnosis Criteria for Self-Report of History with OUD

*These criteria should be applied for potential MOM participants who do not have a clinical history of an OUD diagnosis. Complete screening tool and document level of severity into the MOM CCM. If clinically-licensed to provide a diagnosis, MOM case managers should see Appendix C for clinical diagnosis codes.*

**DSM-V Criteria for Diagnosis of Opioid Use Disorder[23]**

| **Diagnostic Criteria**<br>A. A problematic pattern of opioid use leading to clinically significant impairment or distress as manifested by at least two of the following, occurring within a 12 month period: | |
|---|---|
| Check all that apply | |
| | Opioids are often taken in larger amounts or over a longer period of time than intended. |
| | There is a persistent desire or unsuccessful efforts to cut down or control opioid use. |
| | A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects. |
| | Craving, or a strong desire to use opioids. |
| | Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home. |
| | Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids. |
| | Important social, occupational or recreational activities are given up or reduced because of opioid use. |
| | Recurrent opioid use in situations in which it is physically hazardous. |
| | Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids. |
| | Tolerance, as defined by either of the following:<br>(a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect<br>(b) markedly diminished effect with continued use of the same amount of an opioid |
| | Withdrawal, as manifested by either of the following:<br>(a) the characteristic opioid withdrawal syndrome<br>(b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms |

[23] Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association page 541.

**Total Number of Boxes Checked: _____**

**Severity:**

- **Mild:** 2-3 symptoms
- **Moderate:** 4-5 symptoms
- **Severe:** 6 or more symptoms

*Specify if:*

**In early remission:** After full criteria for OUD were previously met, none of the criteria for OUD have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use opioids,” may be met).

**In sustained remission:** After full criteria for OUD were previously met, none of the criteria for OUD have been met for at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use opioids,” may be met).

## Appendix C. OUD ICD-9 and ICD-10 Diagnosis Codes and Description

*ICD-9 codes included, as the MOM model does dictate a historical timeline for OUD diagnosis without constraints to when a diagnosis occurred.*

| ***Code and Description*** | |
|---|---|
| **ICD-9-CM codes** | **Description** |
| 30400 | Opioid type dependence, unspecified |
| 30401 | Opioid type dependence, continuous |
| 30402 | Opioid type dependence, episodic |
| 30403 | Opioid type dependence, in remission |
| 30470 | Combinations of opioid type drug with any other drug dependence, unspecified |
| 30471 | Combinations of opioid type drug with any other drug dependence, continuous |
| 30472 | Combinations of opioid type drug with any other drug dependence, episodic |
| 30473 | Combinations of opioid type drug with any other drug dependence, in remission |
| 30550 | Opioid abuse, unspecified |
| 30551 | Opioid abuse, continuous |
| 30552 | Opioid abuse, episodic |
| **ICD-10-CM codes** | **Description** |
| F111 | Opioid abuse |
| F1110 | Opioid abuse, uncomplicated |
| F1112 | Opioid abuse with intoxication |
| F112 | Opioid dependence |
| F1120 | Opioid dependence, uncomplicated |
| F1121 | Opioid dependence, in remission |
| F1122 | Opioid dependence with intoxication |
| F1123 | Opioid dependence with withdrawal |
| F1124 | Opioid dependence with opioid-induced mood Disorder |
| F1128 | Opioid dependence with other opioid-induced disorder |
| F1129 | Opioid dependence with unspecified opioid-induced disorder |
| F1190 | Opioid use, unspecified, uncomplicated |
| F11921 | Opioid use, unspecified, with intoxication Delirium |
| F1194 | Opioid use, unspecified with opioid-induced mood disorder |
| F1199 | Opioid use, unspecified with unspecified opioid-induced disorder |

| | |
|---|---|
| F11120 | Opioid abuse with intoxication, uncomplicated |
| F11121 | Opioid abuse with intoxication delirium |
| F11122 | Opioid abuse with intoxication with perceptual disturbance |
| F11129 | Opioid abuse with intoxication, unspecified |
| F1114 | Opioid abuse with opioid-induced mood disorder |
| F1115 | Opioid abuse with opioid-induced psychotic disorder |
| F11150 | Opioid abuse with opioid-induced psychotic disorder with delusions |
| F11151 | Opioid abuse with opioid-induced psychotic disorder with hallucinations |
| F11159 | Opioid abuse with opioid-induced psychotic disorder, unspecified |
| F1118 | Opioid abuse with other opioid-induced disorder |
| F11181 | Opioid abuse with opioid-induced sexual dysfunction |
| F11182 | Opioid abuse with opioid-induced sleep disorder |
| F11188 | Opioid abuse with other opioid-induced disorder |
| F1119 | Opioid abuse with unspecified opioid-induced disorder |
| F11220 | Opioid dependence with intoxication, uncomplicated |
| F11221 | Opioid dependence with intoxication delirium |
| F11222 | Opioid dependence with intoxication with perceptual disturbance |
| F11229 | Opioid dependence with intoxication, unspecified |
| F1125 | Opioid dependence with opioid-induced psychotic disorder |
| F11250 | Opioid dependence with opioid-induced psychotic disorder with delusions |
| F11251 | Opioid dependence with opioid-induced psychotic disorder with hallucinations |
| F11259 | Opioid dependence with opioid-induced psychotic disorder, unspecified |
| F11281 | Opioid dependence with opioid-induced sexual dysfunction |
| F11282 | Opioid dependence with opioid-induced sleep disorder |
| F11288 | Opioid dependence with other opioid-induced disorder |
| F119 | Opioid use, unspecified |
| F1192 | Opioid use, unspecified with intoxication |
| F11920 | Opioid use, unspecified with intoxication, uncomplicated |
| F11922 | Opioid use, unspecified with intoxication with perceptual disturbance |
| F11929 | Opioid use, unspecified with intoxication, unspecified |
| F1193 | Opioid use, unspecified with withdrawal |
| F1195 | Opioid use, unspecified with opioid-induced psychotic disorder |
| F11950 | Opioid use, unspecified with opioid-induced psychotic disorder with delusions |
| F11951 | Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations |
| F11959 | Opioid use, unspecified with opioid-induced psychotic disorder, unspecified |

| | |
|---|---|
| F1198 | Opioid use, unspecified with other specified opioid-induced disorder |
| F11981 | Opioid use, unspecified with opioid-induced sexual dysfunction |
| F11982 | Opioid use, unspecified with opioid-induced sleep disorder |
| F11988 | Opioid use, unspecified with other opioid-induced disorder |

## Appendix D. Screenings Frequency and Approach

**Table D1. Overview**

| | Approach | Intake | 90 Days | Third Trimester | Postpartum |
|---|---|---|---|---|---|
| **HRSN** | Modified AHC tool | X | | X | X |
| **Depression** | Embedded in HRSN, with additional requirements in the case of a positive result | X | | X | X |
| **Anxiety** | GAD-7 | X | | | X |
| **Tobacco** | Embedded in HRSN | X | | X | X |
| **Alcohol** | Embedded in HRSN | X | | X | X |
| **PAM** | Flourish tool | X | X | | |
| **SUD** | NIDA-Modified ASSIST | | | | X |
| **Self-Report** | Self-Report Template | X | | X* | X |

*If not captured at intake.

### Health-Related Social Needs (HRSN)

Administer modified Accountable Health Communities HRSN Tool accessed via CRISP.

***Timing*:** Administered within 7 days of model enrollment, a second time during the participant's third trimester, then a third time after the end of pregnancy within 60 days postpartum. Subsequent screenings administered every three months or as needed for participants who continue to be enrolled in Medicaid.

### Depression

Captured through HRSN screening tool using the same screening and scoring methodologies as the PHQ-2; for those who screen positive (score of 3 or above on PHQ-2 questions) administer the remaining 7 questions of the PHQ-9 (captured and stored separately) and create a follow-up plan.

***Timing*:** Administered as part of the HRSN tool within 7 days of model enrollment, during the third trimester, and at the end of pregnancy within 60 days postpartum. Subsequent screenings administered as needed as part of the HRSN screening cadence for participants who continue to be enrolled in Medicaid. Repeat the same procedure in deploying the PHQ-9 screening if a participant screens positive and create a follow-up plan for those participants.

### Anxiety

Captured through GAD-7 screening (stored separately), with indication of participant's level of anxiety documented.

***Timing*:** Administered at a minimum within 7 days of model enrollment and after the end of pregnancy within 60 days postpartum. Subsequent screenings administered as needed for participants who continue to be enrolled in Medicaid.

## Tobacco

Capture through HRSN screening tool; added questions inquiring into the number of cigarettes smoked, in the case of a positive result. Refer to tobacco cessation for those who screen positive.

***Timing*:** For beneficiaries who enroll in the MOM Model during their first or second trimester, it is recommended an additional tobacco screening be completed during the third trimester. In total, these beneficiaries should receive at least three screenings: within 7 days of Model enrollment, during the third trimester, and within 60 days after the end of pregnancy. Subsequent screenings administered as needed as part of the HRSN screening cadence for participants who continue to be enrolled in Medicaid.

## Alcohol

Capture through HRSN screening tool.

***Timing*:** Administered at a minimum within 7 days of model enrollment, during the participant's third trimester, and after the end of pregnancy within 60 days postpartum. Subsequent screenings administered as needed as part of the HRSN screening cadence for participants who continue to be enrolled in Medicaid.

## Patient Activation Measure

Enter directly into the Flourish tool administered by Insignia Health, document completion into Care Coordination Module.

***Timing*:** Administered within 7 days of model enrollment and a follow-up at least 90 days from initial assessment.

## SUD (NIDA-Modified ASSIST)

Administered through the NIDA-Modified ASSIST screening tool (stored separately), document completion and any interventions offered as a result of participant's score into Care Coordination Module.

***Timing*:** Administered once within 60 days after the end of pregnancy.

## Self-Report Template

Administered by the MOM case manager, document for data collection purposes.

***Timing:*** Administered at intake (Q1-11) and within 60 days postpartum (Q12-25). More sensitive questions may be asked in the third trimester when rapport has been established.

## Appendix E: Health-Related Social Needs, Depression, Anxiety, Self-Report Template, and SUD Screenings

### Health-Related Social Needs

*(Accessed via CRISP)*

| Question | Response |
|---|---|
| **Domain: Living Situation** | |
| What is your living situation today? | I have a steady place to live |
| | I have a place to live today, but I am worried about losing it in the future |
| | I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) |
| Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY | Pests such as bugs, ants, or mice |
| | Mold |
| | Lead paint or pipes |
| | Lack of heat |
| | Oven or stove not working |
| | Smoke detectors missing or not working |
| | Water leaks |
| | None of the above |
| **Domain: Food** | |
| Some people have made the following statements about their food situation. Please answer whether these statements were OFTEN, SOMETIMES OR NEVER true for you and your household in the last 12 months.<br><br>Within the past 12 months, you worried that your food would run out before you got money to buy more. | Often true |
| | Sometimes true |
| | Never true |
| Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. | Often true |
| | Sometimes true |
| | Never true |
| **Domain: Transportation** | |

| | |
|---|---|
| In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living? | Yes |
| | No |
| **Domain: Utilities** | |
| In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? | Yes |
| | No |
| | Already shut off |
| **Domain: Safety**<br>** A score of 11 or more when the numerical values for answers to the following questions posed in this domain are added indicates a positive result that the person might not be safe.* | |
| Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions.<br><br>How often does anyone, including family and friends, physically hurt you? | Never (1) |
| | Rarely (2) |
| | Sometimes (3) |
| | Fairly often (4) |
| | Frequently (5) |
| How often does anyone, including family and friends, insult or talk down to you? | Never (1) |
| | Rarely (2) |
| | Sometimes (3) |
| | Fairly often (4) |
| | Frequently (5) |
| How often does anyone, including family and friends, threaten you with harm? | Never (1) |
| | Rarely (2) |
| | Sometimes (3) |
| | Fairly often (4) |
| | Frequently (5) |
| How often does anyone, including family and friends, scream or curse at you? | Never (1) |
| | Rarely (2) |
| | Sometimes (3) |
| | Fairly often (4) |
| | Frequently (5) |
| **Domain: Financial Strain** | |

| | |
|---|---|
| How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is… | Very hard |
| | Somewhat hard |
| | Not hard at all |
| **Domain: Employment** | |
| Do you want help finding or keeping work or a job? | Yes, help finding work |
| | Yes, help keeping work |
| | I do not need or want help |
| **Domain: Education** | |
| Do you speak a language other than English at home? | Yes |
| | No |
| Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent. | Yes |
| | No |
| **Domain: Substance Use**<br><br>** Additional questions may be added pending CMMI requirements and other new data elements. Please refer separately to SUD screening during the postpartum period to monitor for risk and provide health education.* | |
| During the last month, how many alcoholic drinks did you have in an average week? A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink. | I Didn't Drink in the Last Month |
| | Less than 1 Drink a Week |
| | 1 to 3 Drinks a Week |
| | 4 to 7 Drinks a Week |
| | 8 to 13 Drinks a Week |
| | 14 Drinks or More a Week |
| | Did Not Answer/Unknown |
| How many times in the past 12 months have you used tobacco products (not including electronic cigarettes)? | Never |
| | Once or twice |
| | Monthly |
| | Weekly |

| | |
|---|---|
| | Daily or almost daily |
| On average, how many cigarettes do you smoke per day? | (free text) |
| **Domain: Mental Health**<br><br>** Note: The AHC mental health questions are equivalent to the PHQ-2 depression screening. To meet the MOM depression screening requirement, if a MOM participant initially screens positive (3 or above on the first two questions posed in this section), MOM case managers will conduct the full PHQ-9 with the participant. After completing this section, please administer and score the GAD-7 separately.* | |
| Over the past 2 weeks, how often have you been bothered by any of the following problems?<br><br>Little interest or pleasure in doing things? | Not at all (0) |
| | Several days (1) |
| | More than half the days (2) |
| | Nearly every day (3) |
| Feeling down, depressed, or hopeless? | Not at all (0) |
| | Several days (1) |
| | More than half the days (2) |
| | Nearly every day (3) |
| Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days? | Not at all |
| | A little bit |
| | Somewhat |
| | Quite a bit |
| | Very much |
| **Domain: Family and Community Support** | |
| If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need? | I don't need any help |
| | I get all the help I need |
| | I could use a little more help |
| | I need a lot more help |
| How often do you feel lonely or isolated from those around you? | Never |
| | Rarely |
| | Sometimes |

| | |
|---|---|
| | Often |
| | Always |
| **Domain: Maternal Child Health** | |
| Who can you count on for help/support during this pregnancy? | (Free text) |
| Who can you talk to about stressful things in your life? | (Free text) |
| Do you need daycare for your child? | Yes |
| | No |
| If yes, would you like help finding it? | Yes |
| | No |
| | Maybe later |

## Depression

*To be administered in the case of a positive PHQ-2 result (score of 3 or more) during HRSN.*

**PHQ-9 Screening[24]**

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|---|
| 1 | Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2 | Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3 | Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4 | Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5 | Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6 | Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7 | Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8 | Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9 | Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**Total score: 1-4 minimal depression; 5-9 mild depression; 10-14 moderate depression; 15-19 moderately severe depression; 20-27 severe depression**

[24] PHQ9 Copyright © Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD ® is a trademark of Pfizer Inc.

## Anxiety

**GAD-7 Screening[25]**

| **Over the last 2 weeks, how often have you been bothered by the following problems?** | | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|---|
| 1 | Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2 | Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3 | Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4 | Trouble relaxing | 0 | 1 | 2 | 3 |
| 5 | Being so restless it is hard to sit still | 0 | 1 | 2 | 3 |
| 6 | Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7 | Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

**Total score: 0-5 mild anxiety; 6-10 moderate anxiety; 11-15 moderately severe anxiety; 15-21 severe anxiety**

[25] Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166:1092-7.

## Self-Report Template

### To be Asked at Intake - CRISP Initial Care Plan

1. Is the beneficiary receiving pharmacotherapy treatment (for OUD); if so what type of medication?

   ☐None
   ☐Buprenorphine
   ☐Naltrexone
   ☐Methadone
   ☐Other

2. Did the beneficiary have health insurance before they became pregnant (with this pregnancy)?

   ☐Yes, Medicaid
   ☐Yes, Private Insurance
   ☐Yes, Other
   ☐No
   ☐Not Known

3. What is the beneficiary's relationship status at intake?

   ☐Married, living with spouse
   ☐Married, not living with spouse
   ☐Living with a partner
   ☐In a relationship, not living together
   ☐Not in a relationship right now

4. Does the beneficiary have a high school diploma or GED?

   ☐Yes
   ☐No

5. Did the beneficiary use any of the following substances in the last year? Check all that apply.

   ☐Alcohol
   ☐Cigarettes/Other Tobacco
   ☐Vaping/Electronic Nicotine Delivery System
   ☐Cannabis
   ☐Amphetamines
   ☐Benzodiazepine
   ☐None

6. What is the beneficiary’s current HIV status?

☐ Positive
☐ Negative
☐ Beneficiary declined
☐ Not assessed

7. What is the beneficiary's current Hepatitis C status?

   ☐ Positive
   ☐ Negative
   ☐ Beneficiary declined
   ☐ Not assessed

8. Has the beneficiary ever had a prior birth (live born or still born)?

   ☐Yes
   ☐No

9. If the beneficiary has had a prior birth (live born or still born), what is the birthdate of the beneficiary's last baby?

   · YYYY-MM-DD

10. Has the beneficiary ever experienced any of the following outcomes from a prior pregnancy? Check all that apply.

    ☐Premature (<37 weeks)
    ☐Low Birthweight (<2500g)
    ☐Stillborn infant
    ☐Infant diagnosed with NAS
    ☐Unknown
    ☐None
    ☐Not applicable

11. If the beneficiary has been pregnant before, have they had any of the following prior pregnancy risk factors? Check all that apply.

    ☐Preeclampsia or pregnancy induced hypertension
    ☐Gestational Diabetes
    ☐Gestational Hypertension
    ☐HELLP Syndrome
    ☐Hemorrhage
    ☐Other
    ☐Unknown
    ☐None
    ☐Not Applicable

**To be Asked after beneficiary rapport established - up to 60 days postpartum - CRISP Care Plan Update**

12. Did the beneficiary start using any of the following before the age of 18? Check all that apply.

    ☐Alcohol
    ☐Cigarettes/Other Tobacco
    ☐Vaping/Electronic Nicotine Delivery System
    ☐Cannabis
    ☐Amphetamines
    ☐Benzodiazepine
    ☐None

13. Has the beneficiary ever experienced any of the following? Check all that apply

    ☐Sexual abuse
    ☐Physical Abuse
    ☐Emotional Abuse
    ☐Transactional Sex
    ☐None of the Above

14. Have any of the beneficiary's prior children ever been placed outside of the home?

    ☐Yes
    ☐No
    ☐Not Known
    ☐Not Applicable

Note: For Question 13, select “none of the above” if MOM model participant declines to answer. For Question 14, select “not known” if MOM model participant declines to answer.

**To be Asked Postpartum (within 60 days with PHQ-9 and HSRN screening) - CRISP Care Plan Update**

15. What many weeks gestation was the infant at the time of birth?

    Please express your response in number of weeks.
    [free text]

16. Did the beneficiary receive pharmacotherapy treatment (for OUD) at the time of delivery; if so what type of medication?

    ☐Not Applicable
    ☐Buprenorphine
    ☐Naltrexone
    ☐Methadone
    ☐Other

17. Did the beneficiary receive pharmacotherapy treatment (for OUD) during the postpartum period; if so what type of medication?

    ☐None

☐Buprenorphine
☐Naltrexone
☐Methadone
☐Other

18. Did the infant have a positive screening for NAS?

☐Yes
☐No
☐Not known

19. Did the infant have a positive screening for opioids?

☐Yes
☐No
☐Not known

20. Did the infant receive pharmacotherapy treatment (for NAS)?

☐Yes
☐No
☐Not known

21. Did the beneficiary receive any of the following during labor to manage pain?

☐Epidural
☐IV Narcotics
☐Other
☐No/None

22. What was the beneficiary's final delivery method for MOM pregnancy?

☐Vaginal
☐Vaginal, induced
☐Vaginal, augmented
☐Vaginal, VBAC
☐Emergency C-Section
☐Planned C-Section

23. Did the beneficiary have their infant removed for out-of-home placement (e.g., goes to social services, then the response is yes)? **Note this is required to be reported once infant date of birth field is filled for quarterly reporting*

☐Yes
☐No

Note: For Question 23, select “no” if MOM model participant declines to answer.

24. What contraceptive method is the beneficiary using (or planning to use). **This should be assessed at the first postpartum visit.**

☐None
☐Natural family planning
☐Pull out method
☐Barrier or spermicide
☐Hormonal
☐Injectable
☐LARC
☐Tubal ligation
☐Other
☐Unknown

25. What method is the beneficiary using to feed their infant?

☐Breastfeeding
☐Pumping breastmilk for bottle or catheter feeding
☐Both breastfeeding and pumping breastmilk for bottle or catheter feeding
☐Breastfeeding or pumping and supplementing breastmilk with formula
☐Formula feeding only
☐Unknown

## Substance Use Disorder

### NIDA-Modified ASSIST V2.0[26]

**Name: ..... Sex ( ) F ( ) M Age.....**

**Interviewer..... Date ...../...../.....**

**Instructions:** Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

[26] The NIDA Quick Screen was adapted from a single-question screen for drug use in primary care by Smith et al. 2010 and the National Institute on Alcohol Abuse and Alcoholism's Helping Patients Who Drink Too Much: A Clinician's Guide Updated 2005 Edition. The NIDA-Modified ASSIST (NM ASSIST) was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST).

| Question 1 of 8, NIDA-Modified ASSIST<br><br>**In your *LIFETIME*, which of the following substances have you ever used?**<br>***Note for Physicians: For prescription medications, please report nonmedical use only.*** | Yes | No |
|---|---|---|
| **a. Cannabis** (marijuana, pot, grass, hash, etc.) | | |
| **b. Cocaine** (coke, crack, etc.) | | |
| **c. Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | | |
| **d. Methamphetamine** (speed, crystal meth, ice, etc.) | | |
| **e. Inhalants** (nitrous oxide, glue, gas, paint thinner, etc.) | | |
| **f. Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.) | | |
| **g. Hallucinogens** (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | | |
| **h. Street opioids** (heroin, opium, etc.) | | |
| **i. Prescription opioids** (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | | |
| **j. Other – specify:** | | |

- If the patient indicates that the drug used is not listed, please mark **'Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST**.** If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

| Question 2 of 8, NIDA-Modified ASSIST<br>2. In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc)? | Never | Once or Twice | Monthly | Weekly | Daily or Almost Daily |
|---|---|---|---|---|---|
| • Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Cocaine (coke, crack, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Street opioids (heroin, opium, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Other – Specify: | 0 | 2 | 3 | 4 | 6 |

- For patients who report **"Never"** having used any drug in the past 3 months: **Go to Questions 6-8**.
- For any recent **illicit or nonmedical prescription drug use**, go to **Question 3.**

| 3. In the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc)? | Never | Once or Twice | Monthly | Weekly | Daily or Almost Dail |
|---|---|---|---|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 3 | 4 | 5 | 6 |
| b. Cocaine (coke, crack, etc.) | 0 | 3 | 4 | 5 | 6 |
| c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 3 | 4 | 5 | 6 |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 3 | 4 | 5 | 6 |
| e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | 0 | 3 | 4 | 5 | 6 |
| f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.) | 0 | 3 | 4 | 5 | 6 |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 3 | 4 | 5 | 6 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **h.** | **Street Opioids (heroin, opium, etc.)** | 0 | 3 | 4 | 5 | 6 |
| **i.** | **Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)** | 0 | 3 | 4 | 5 | 6 |
| **j.** | **Other – Specify:** | 0 | 3 | 4 | 5 | 6 |

| 4. During the past 3 months, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems? | Never | Once or Twice | Monthly | Weekly | Daily or Almost Daily |
|---|---|---|---|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 4 | 5 | 6 | 7 |
| b. Cocaine (coke, crack, etc.) | 0 | 4 | 5 | 6 | 7 |
| c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 4 | 5 | 6 | 7 |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 4 | 5 | 6 | 7 |
| e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.) | 0 | 4 | 5 | 6 | 7 |
| f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.) | 0 | 4 | 5 | 6 | 7 |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 4 | 5 | 6 | 7 |
| h. Street opioids (heroin, opium, etc.) | 0 | 4 | 5 | 6 | 7 |
| i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 4 | 5 | 6 | 7 |
| j. Other – Specify: | 0 | 4 | 5 | 6 | 7 |

| 5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)? | Never | Once or Twice | Monthly | Weekly | Daily or Almost Daily |
|---|---|---|---|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 5 | 6 | 7 | 8 |
| b. Cocaine (coke, crack, etc.) | 0 | 5 | 6 | 7 | 8 |
| c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 5 | 6 | 7 | 8 |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 5 | 6 | 7 | 8 |
| e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | 0 | 5 | 6 | 7 | 8 |
| f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.) | 0 | 5 | 6 | 7 | 8 |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 5 | 6 | 7 | 8 |
| h. Street Opioids (heroin, opium, etc.) | 0 | 5 | 6 | 7 | 8 |
| i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 5 | 6 | 7 | 8 |
| j. Other – Specify: | 0 | 5 | 6 | 7 | 8 |

**Instructions:** Ask Questions 6 & 7 for all substances **ever used** (i.e., those endorsed in the Question 1).

| 6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)? | No, never | Yes, but not in the past 3 months | Yes, in the past 3 months |
|---|---|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 3 | 6 |
| b. Cocaine (coke, crack, etc.) | 0 | 3 | 6 |
| c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 3 | 6 |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 3 | 6 |
| e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | 0 | 3 | 6 |
| f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.) | 0 | 3 | 6 |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 3 | 6 |
| h. Street opioids (heroin, opium, etc.) | 0 | 3 | 6 |
| i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 3 | 6 |
| j. Other – Specify: | 0 | 3 | 6 |

| 7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)? | No, never | Yes, but not in the past 3 months | Yes, in the past 3 months |
|---|---|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 3 | 6 |
| b. Cocaine (coke, crack, etc.) | 0 | 3 | 6 |
| c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 3 | 6 |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 3 | 6 |
| e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | 0 | 3 | 6 |
| f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.) | 0 | 3 | 6 |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 3 | 6 |
| h. Street opioids (heroin, opium, etc.) | 0 | 3 | 6 |
| i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 3 | 6 |
| j. Other – Specify: | 0 | 3 | 6 |

**Instructions:** Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

| 8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)? | No, never | Yes, but not in the past 3 months | Yes, in the past 3 months |
|---|---|---|---|

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

**Note:** Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

**Tally Sheet for scoring the full NIDA-Modified ASSIST:**

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**Instructions:** For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

| Substance Involvement Score | Total (SI SCORE) |
|---|---|
| **Cannabis (marijuana, pot, grass, hash, etc.)** | |
| **Cocaine (coke, crack, etc.)** | |
| **Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)** | |
| **Methamphetamine (speed, crystal meth, ice, etc.)** | |
| **Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)** | |
| **Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)** | |
| **Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)** | |
| **Street Opioids (heroin, opium, etc.)** | |
| **Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)** | |
| **Other – Specify:** | |

To determine patient's risk level based on his or her SI Score, see the table below:

| Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use | |
|---|---|
| 0-3 | Lower Risk |
| 4-26 | Moderate Risk |
| 27+ | High Risk |